Enhanced Primary Care in West Virginia: Just what the doctor ordered?

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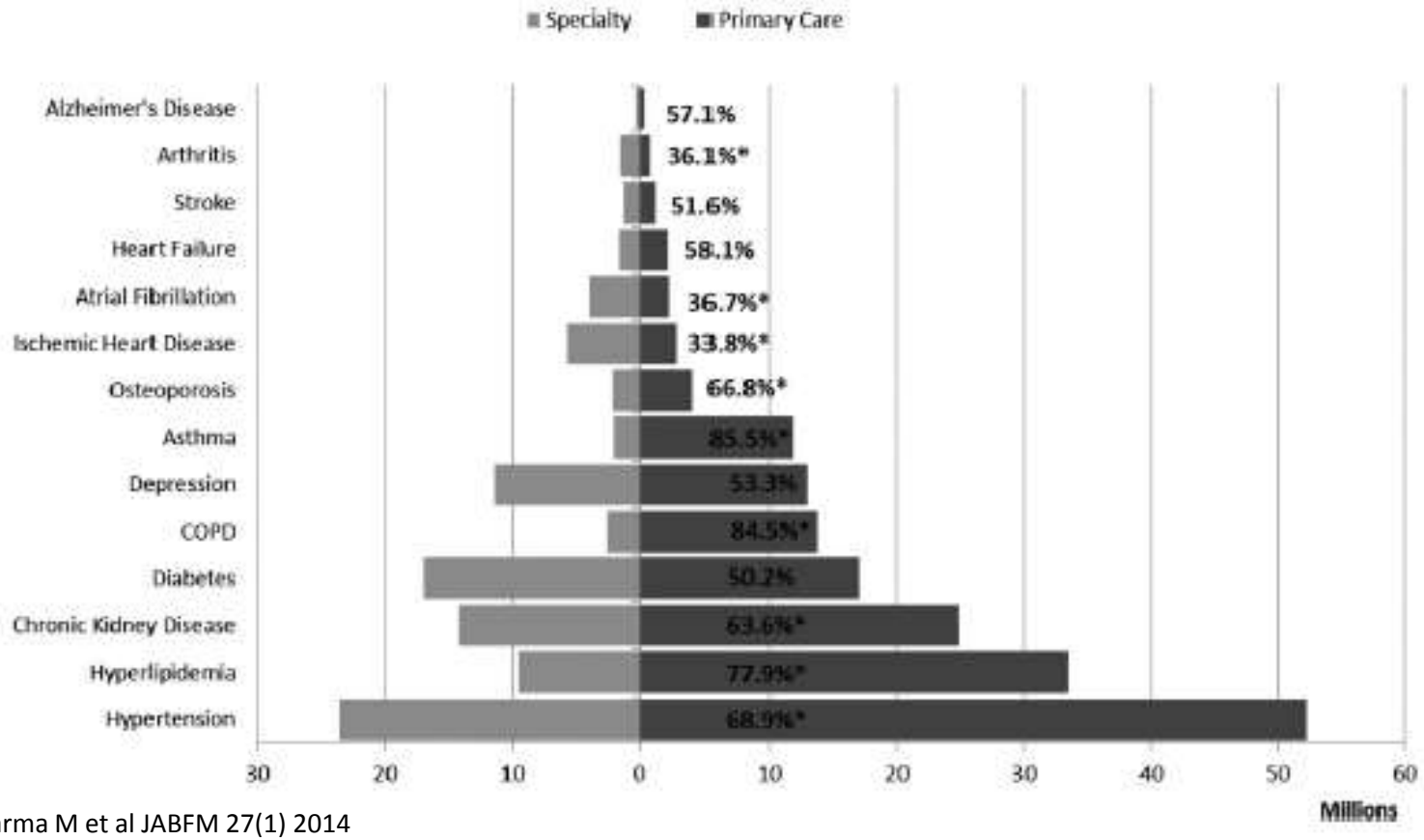
Today's session

- Primary care's role
- Focus on key elements needed to enhance primary care
- Enhanced primary care's impact on cost and quality
  - Some results from our PCMH
  - Case to illustrate how team care affects cost
- Some ideas for statewide enhanced primary care initiative

Primary Care provides much chronic disease care:

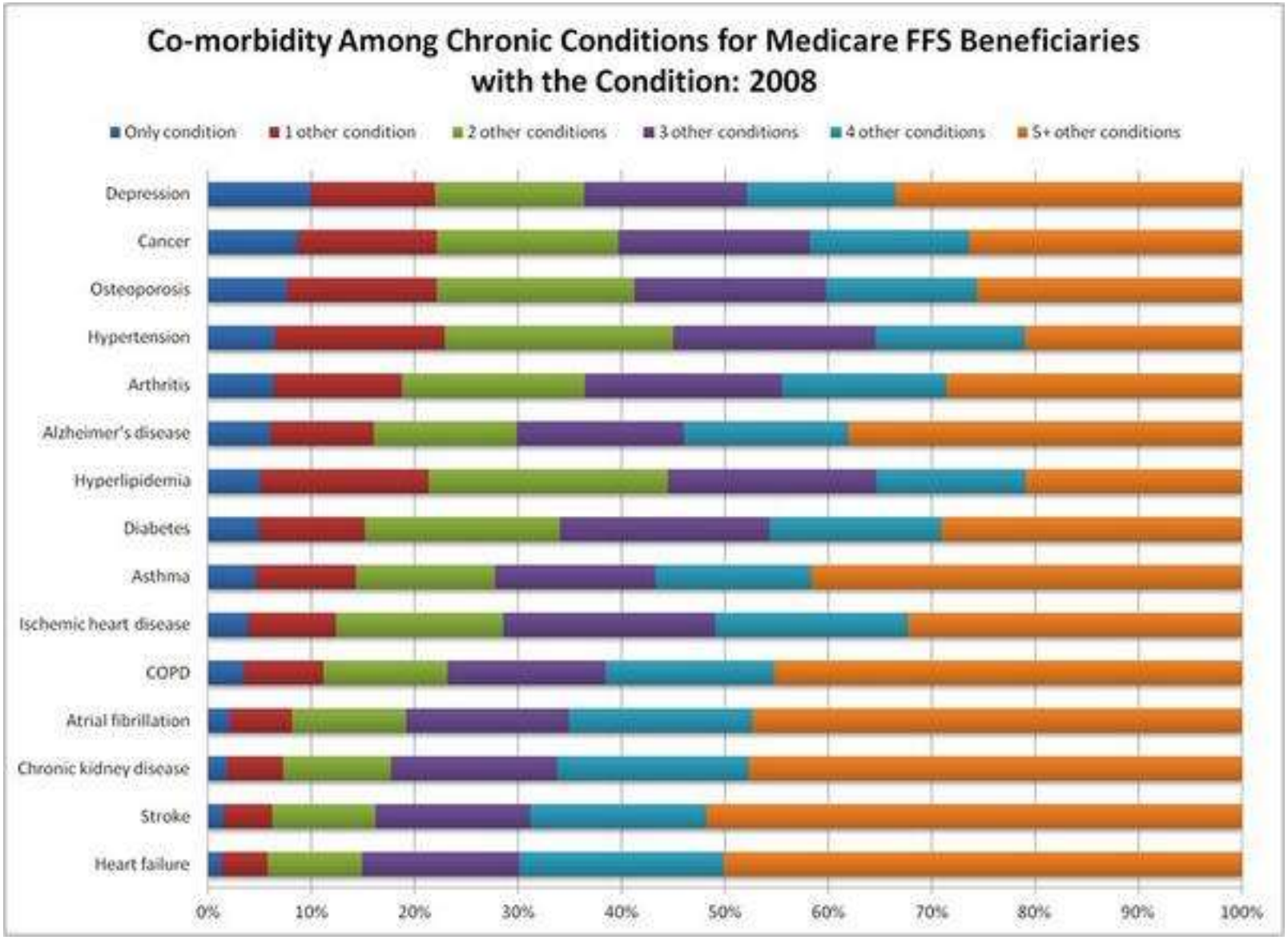
69% of outpatient visits for chronic conditions

Figure 1. Number and percentage of outpatient chronic condition visits by physician type in the past year, based on the 2008 National Ambulatory Medical Care Survey. *$P < 0.05$ significant test done by SAS Procedure Surveyfreq Roa-Scott χ^2 test. COPD, chronic obstructive pulmonary disease.



Sharma M et al JABFM 27(1) 2014

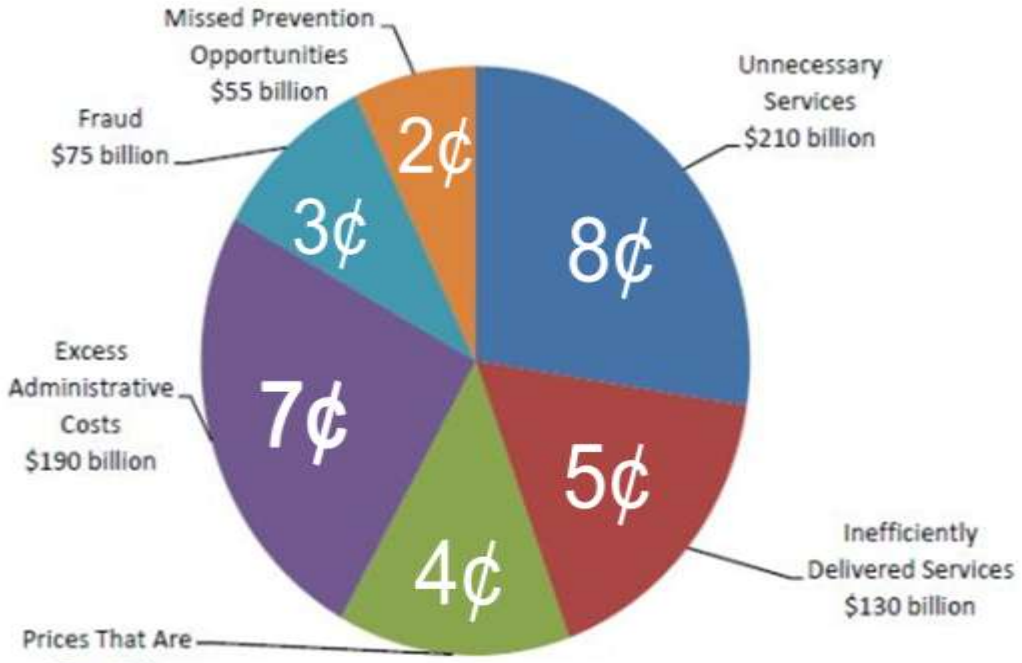
Primary care complexity



Primary Care opportunities to impact cost

Prevention
Reduce ED Utilization
Decrease Admissions
Safer Care Transitions
Better Chronic Disease Care
Better Care Coordination
Timely specialist care
Appropriate use of imaging
Avoid duplication of services
Avoid unnecessary surgeries

SOURCES OF UNNECESSARY SPENDING –IOM 2012



30 cents of every dollar spent

Challenges for the Fifteen minute Visit

- Chronic disease care with high number of interventions
- Complex medication regimens
- Preventive care
- Patient-centered communication and shared decision-making take more time
- Limited time to address barriers and self-care
- Electronic records push more work to providers
- Reimbursement tied to FACE-TO-FACE time

Patient-Centered Medical Home

Evidence-based Enhancements for Primary Care

Patient-Centered Medical Home

Evidence-based Enhancements for Primary Care

ACCESS **TEAM** **POPULATION HEALTH**

WVU FAMILY MEDICINE:
Academic Family Medicine training program
16 faculty physicians & 18 residents

35,000 visits per year
14,000+ unique patients

Epic EHR across the integrated health system

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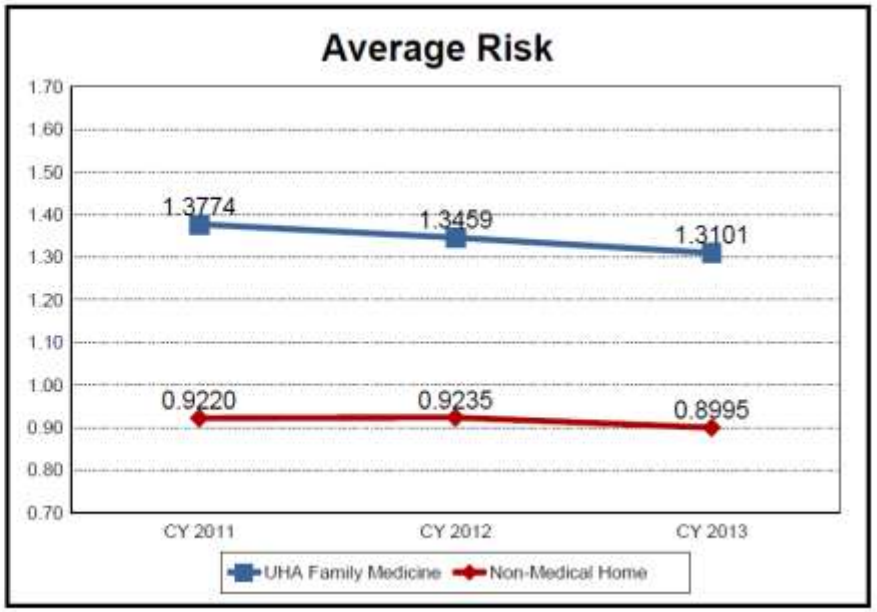
Patient-Centered Care for You and Your Family

Clark. K. Sleeth Family Medicine Center

- Redesign to PCMH began in 2012
- TEAM based care delivery
  - RN Case managers
  - Reorganized discharge clinic
  - Dietitian
  - Team training and workflow redesign
- Enhanced ACCESS
- POPULATION HEALTH
  - Proactive care, care gap strategies, quality improvement

WVU Family Medicine PCMH patients
Compared to Non-PCMH patients in northern WV

Geisinger Health Plan Claims Data



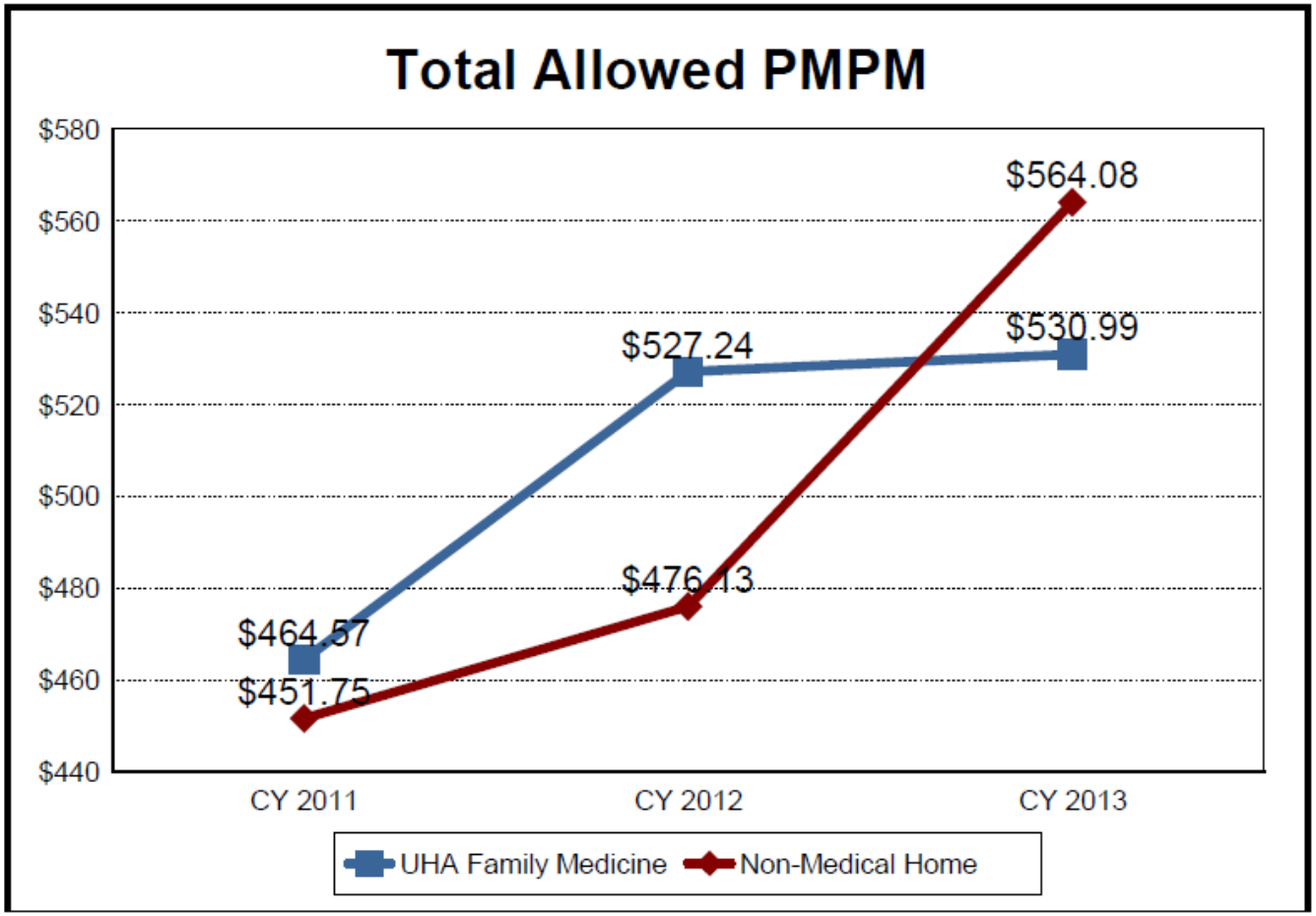
WVU PCMH population with higher risk score than non PCMH patients
1494 average GHP members in WVU PCMH currently

PCMH Total Costs compared to Non-PCMH

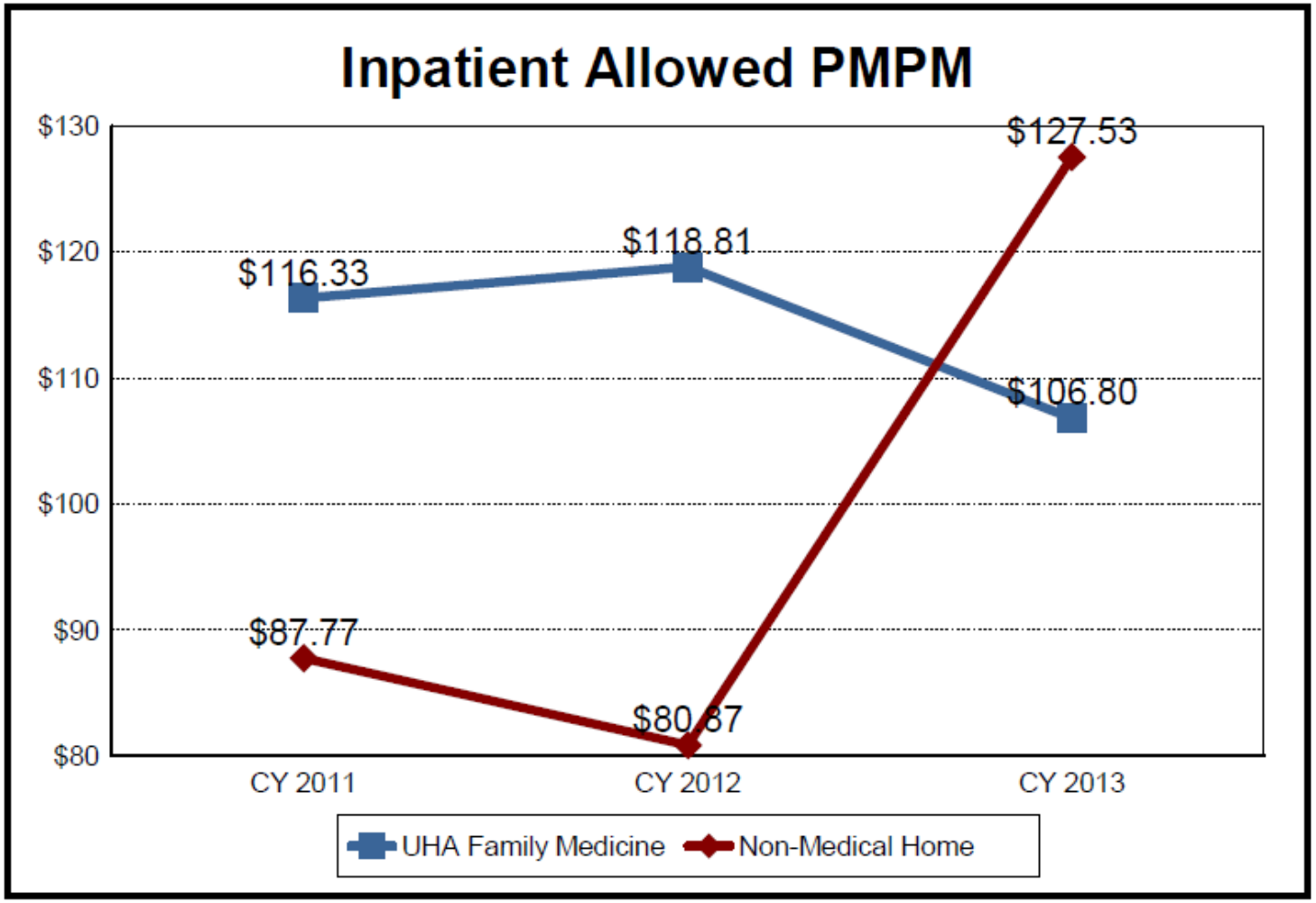
Geisinger Health Plan Claims Data

PCMH redesign began January 2012

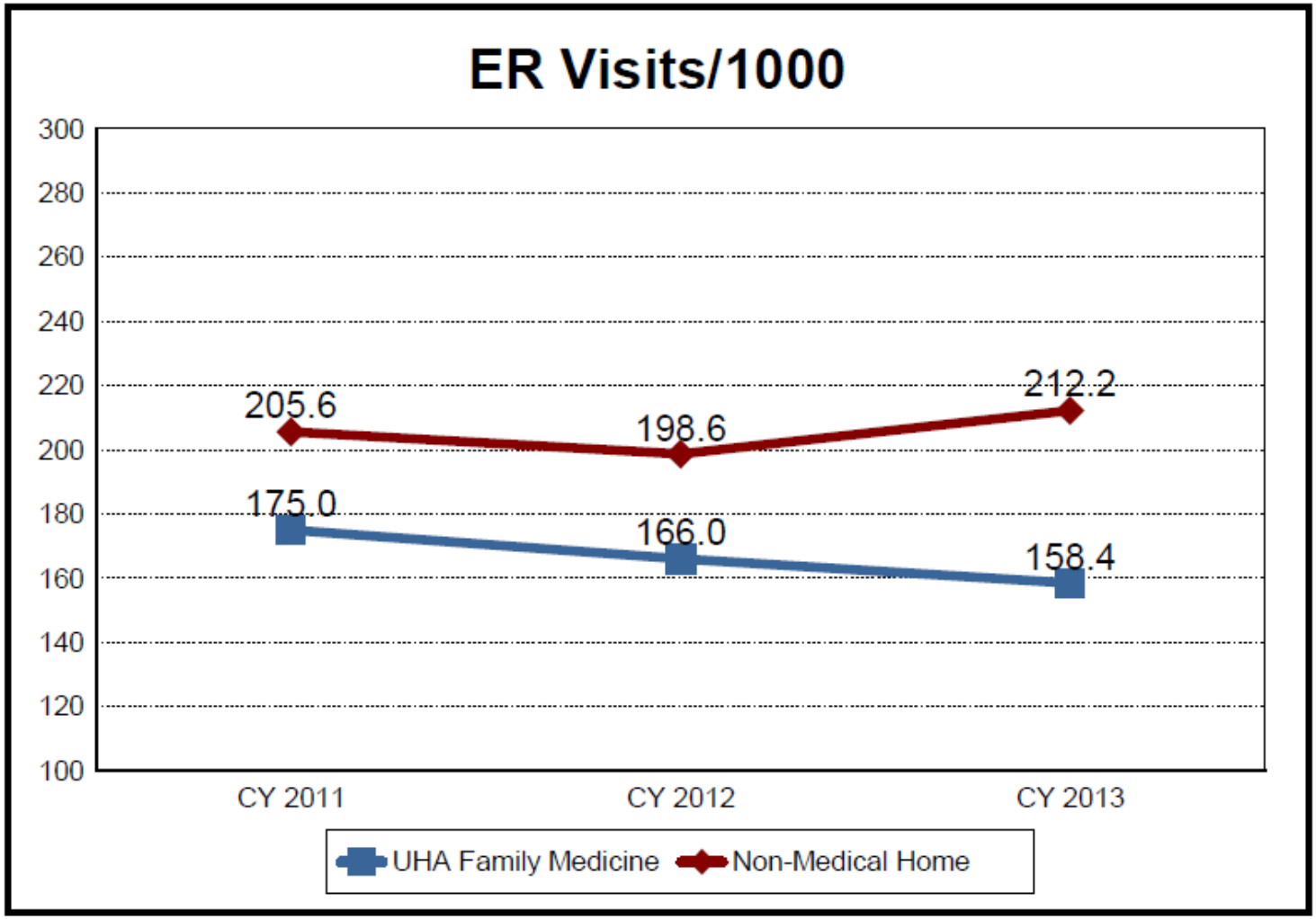
Provider-based billing began 1st quarter 2012



PCMH inpatient costs:
reduced average of $12 pmpm (10% decrease)

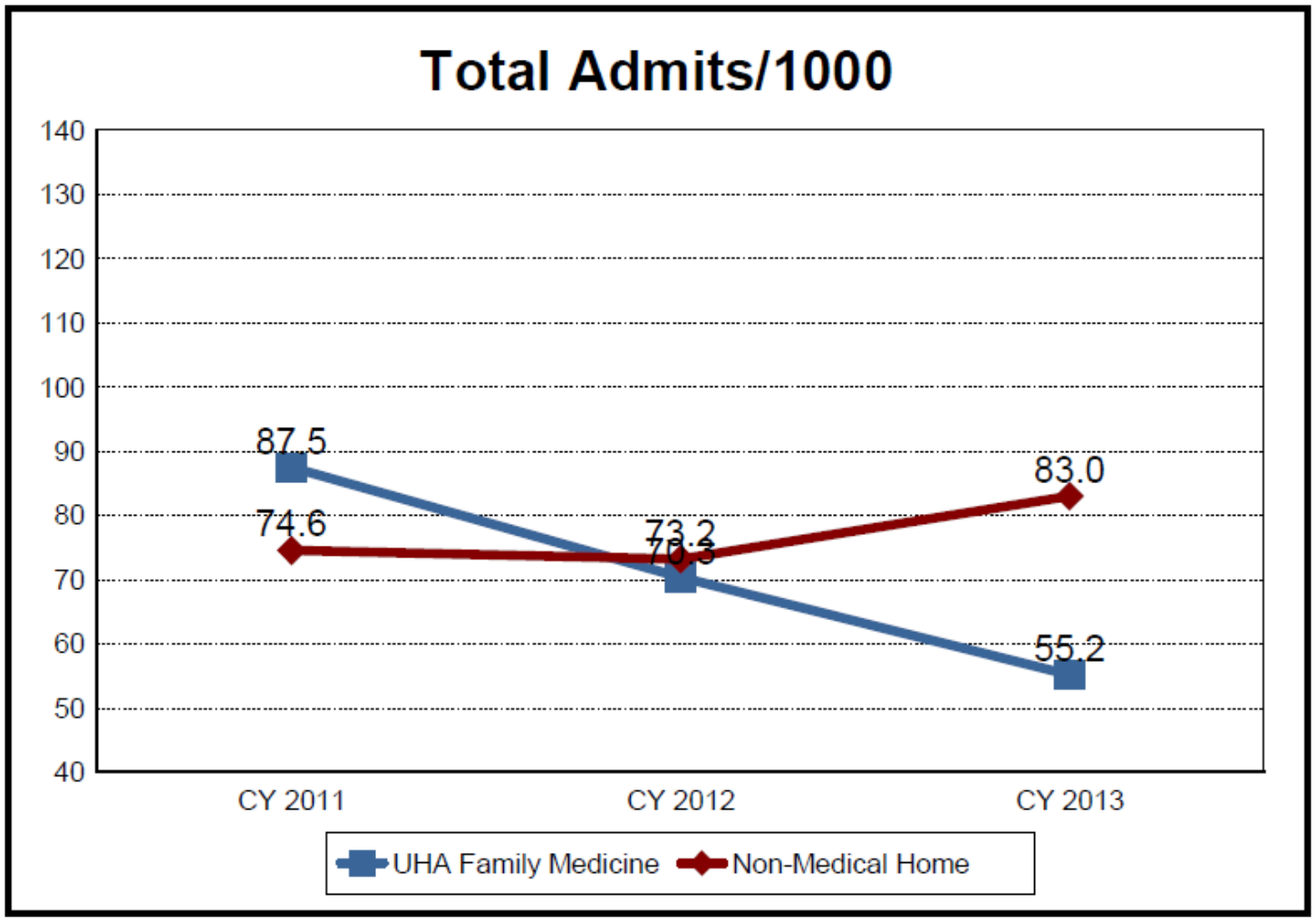


PCMH ER Visits/1000—low baseline, **decreased 4.6%** while Non PCMH *increased* 6.8%

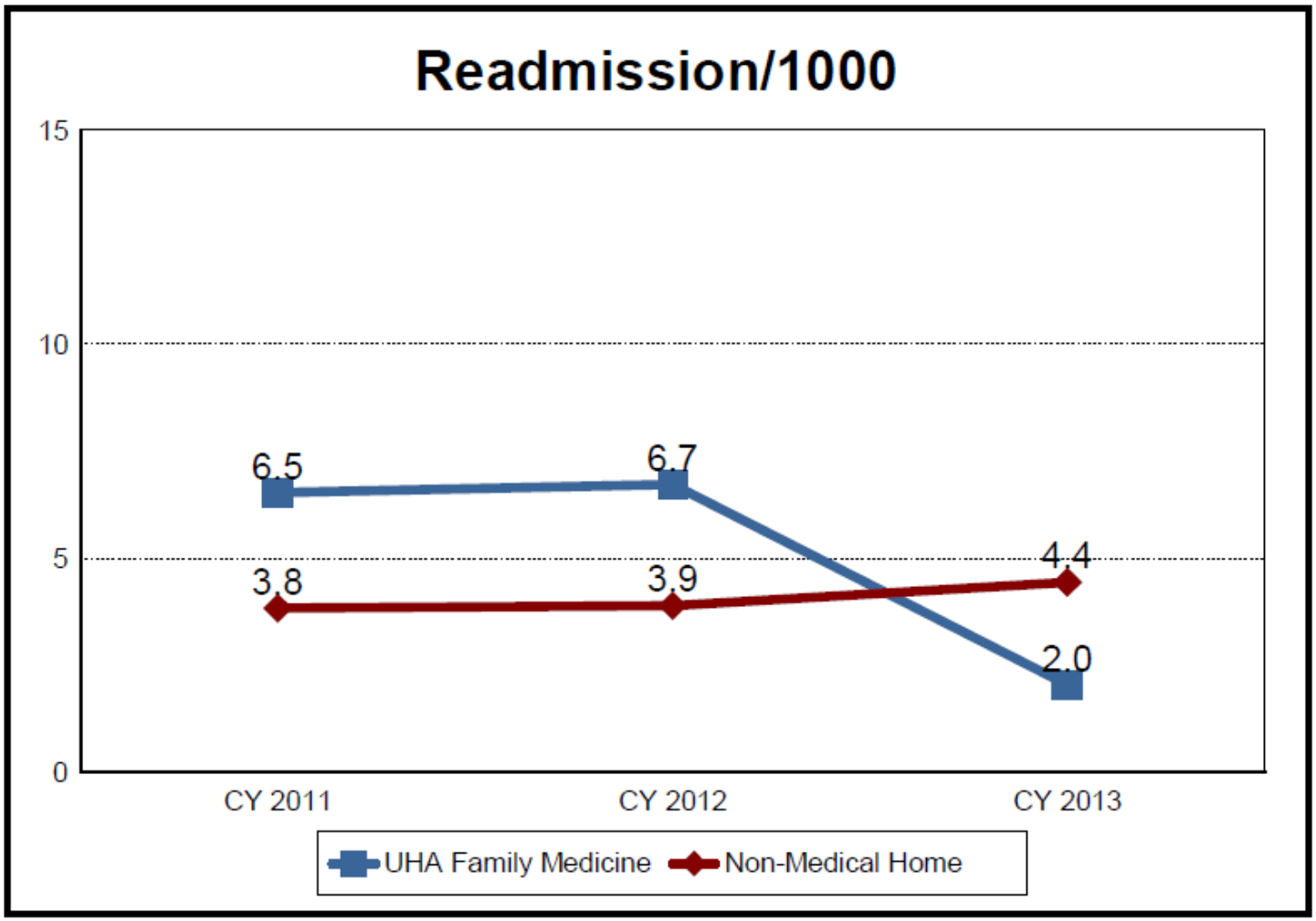


PCMH Inpatient Admits/1000 **reduced 21.5%**

while Non-PCMH Admits *increased* 13%



PCMH Readmission/1000 reduced 69%



Case:

How the Medical Home TEAM approach impacts cost

Barry Smith

35 year old restaurant worker

Type 2 Diabetes with neuropathy

POOR GLUCOSE CONTROL A1c 12 %

Previous TOE ULCER and AMPUTATION

Emergency Dept and HOSP ADMISSION 2011 for

TOE ULCER and BONE INFECTION→ AMPUTATION

ED and HOSP ADMISSION in 2012 DIABETIC FOOT ULCER→ 1 month IV antibiotics

CASE MANAGEMENT after discharge

- Facilitated frequent insulin adjustment –A1c down to 7%
- Monitored chronic wound status
- Coordinated PCP and specialist visits
- Increased self-care ability

HOSP ADMISSION Winter 2012 BONE INFECTION in Chronic Ulcer→ AMPUTATION

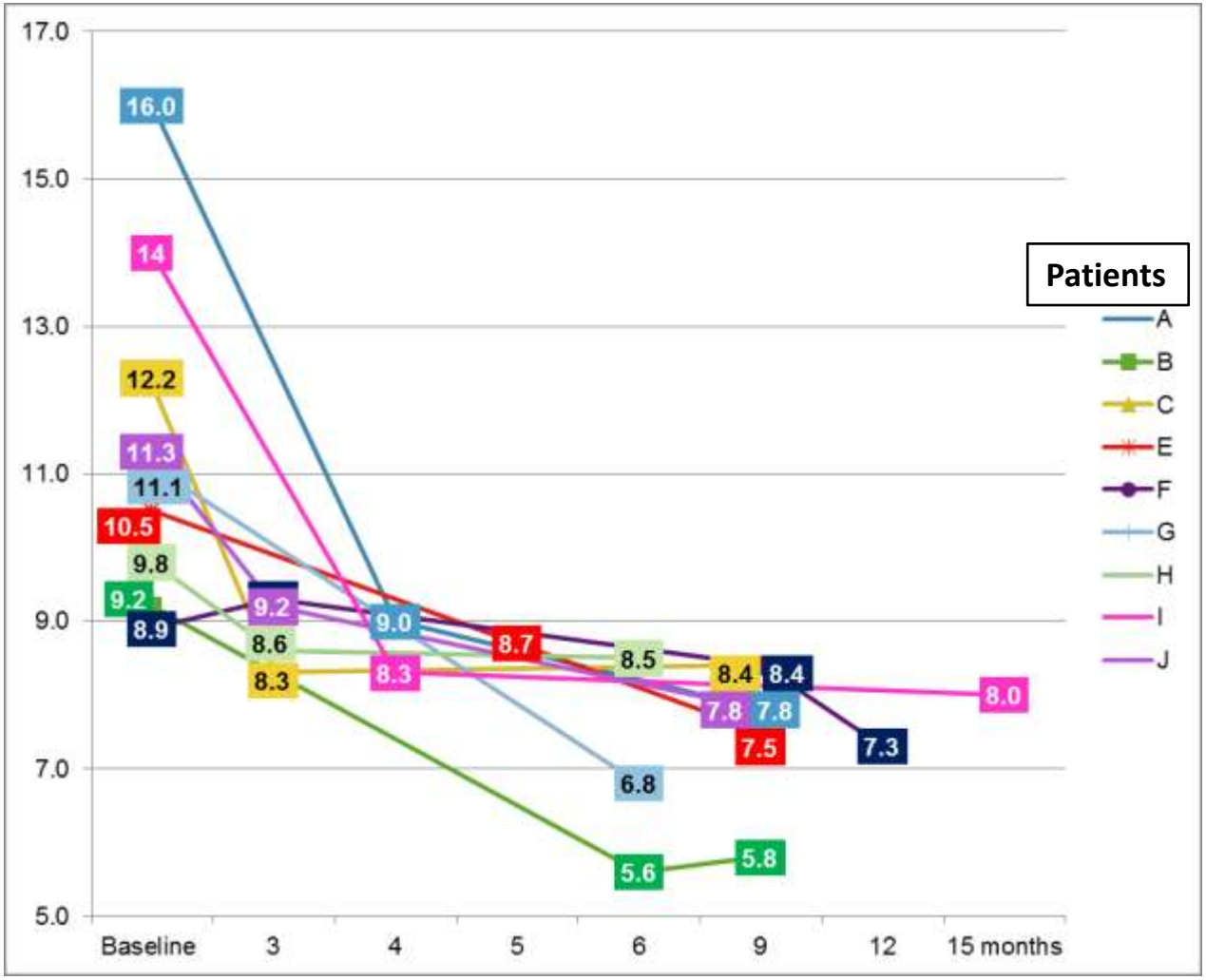
HYPERTENSIVE URGENCY 2013→ CASE MANAGER arranged immediate office visit

2013 NEW FOOT BLISTER → CASE MANAGER, prompt outpatient treatment

No ED visits or hospitalizations since 2012.
Maintained glucose control,
full time work and active lifestyle!

Case Series:
A1C Levels decrease with Case Management

A1C



TIME in Case Management ⟶

Redesigning for TEAM care

- Multidisciplinary Discharge Clinic for care transitions
- Intensive Diabetes Clinic
- Weight Loss Support Group

Essential Elements of Enhanced Primary Care

- TEAM based care delivery
  - Case managers are key component
- Improved ACCESS to primary care team
- POPULATION HEALTH
  - At least basic Registry/quality reporting
  - Care gap management

NCQA PCMH provides strong framework but daunting

✓ requires EHR with strong reporting
✓ incremental approach may be preferable
✓ incentivize NCQA recognition for those able to do full model

Enhanced Primary Care Initiative

- Participating practices would agree to:
  - Participate in Learning collaborative
  - Provide 24/7 telephone advice
  - Provide adequate same day availability
  - Participate in group quality improvement efforts with improvement in some measures
  - Develop PCMH capabilities (not necessarily NCQA)

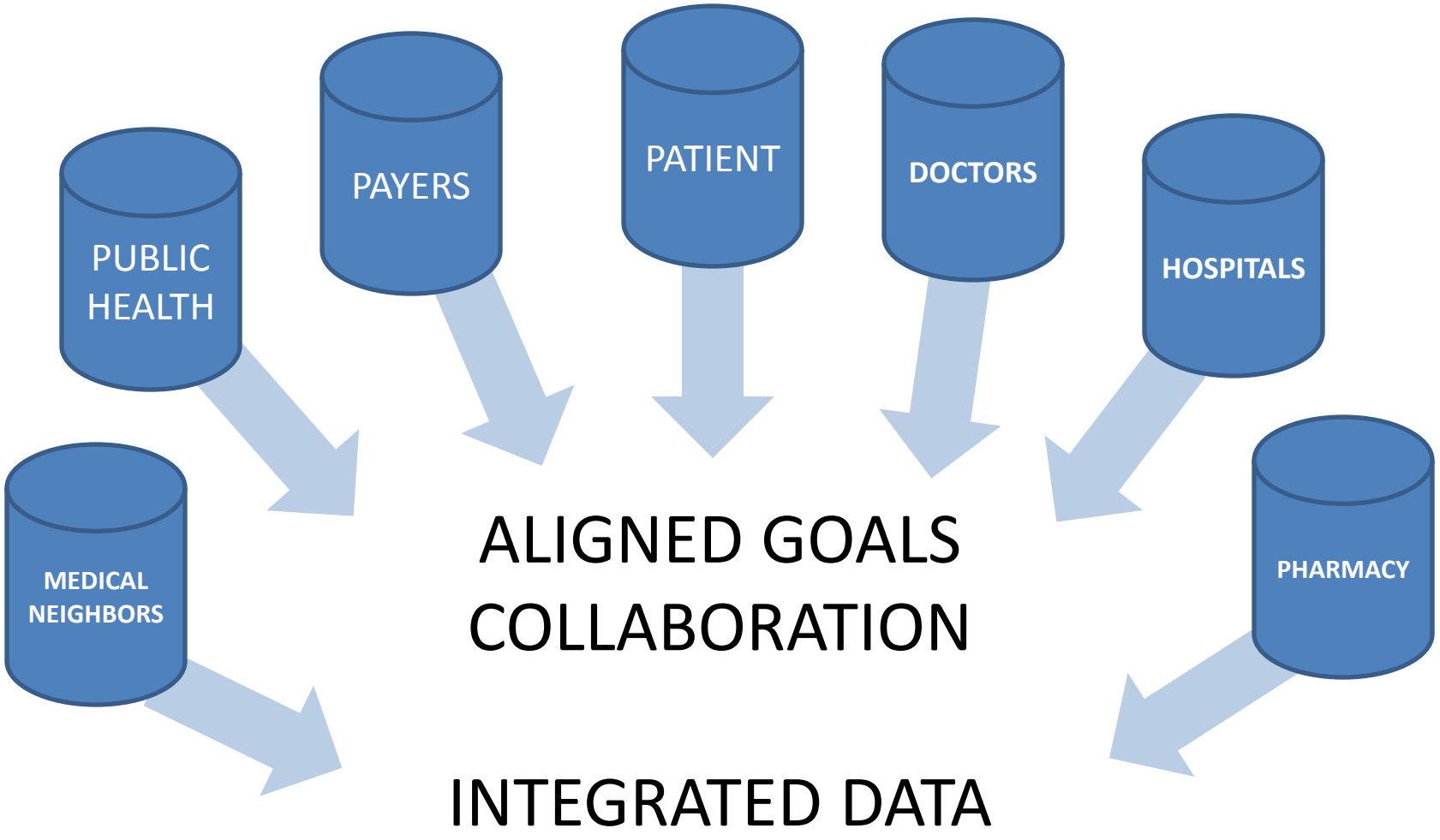
Enhanced Primary Care Initiative

Pay for Value

- Multi-payer Agreement
- Aligned quality metrics and reporting
- Policy aligned with Quality
- Reasonable administrative work
- Payment boost
  - Sufficient payment boost to support WORK of redesign & TEAM
  - Potential for SHARED SAVINGS

Patient-centered Population Health

Whose data is it?



State-wide Enhanced Primary Care Initiative

PRACTICE LEARNING COLLABORATIVE

PRACTICE COACHING
STAFF TRAINING

MULTI-PAYER AGREEMENT

INTEGRATED POPULATION DATA

REGIONAL EXTENSION RESOURCES

BEHAVIORAL MEDICINE
SOCIAL WORKER
DIETITIAN
Shared CASE MANAGERS

COMMUNITY
PARTNERSHIPS

CONNECTED MEDICAL NEIGHBORHOOD

Discussion ?